

The logo consists of a red square with the white letters 'TN' inside. Below the square is a thin blue horizontal line.

TN

Department of
Children's Services



Contract Provider Manual

Section Two (2)-Standard Foster Care Services

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STANDARD FOSTER CARE SERVICES

1. General Characteristics

Standard Foster Care Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate.

The child/youth's emotional and behavioral clinical needs are mild or short-lived and can be met through outpatient services.

2. Admission/Clinical Criteria

Children/youth appropriate for Standard Foster Care:

- a) Are unable to receive the parental care they need in their own home.
- b) Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others.
- c) May be of any adjudication type and are not excluded from admission when their risk is low or they have successfully completed a treatment program.
- d) May have a history of mild mental health or behavioral concerns that require monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms which are mild or transient in nature. These may manifest themselves in difficulty coping socially, occupationally, or in school functioning.
- e) Have a Child and Adolescent Needs and Strengths (CANS) recommending Level 1 intensity of services or have only one rating of 2 or 3 within the domain of child behavioral or emotional needs, such as psychosis, anxiety, or adjustment to trauma. Any ratings within the domain of risk behaviors are low (0 or 1).
- f) Youth in this level of care may experience episodes of behavior needs from time to time. The transient (approximately 2-3 months) need for more intensive or frequent therapeutic interventions may be appropriate and is not considered exclusionary or justification for an increase in level of care.

3. Foster Parents

- a) All new foster parents are required to complete Parents as Tender Healers (PATH) training and core topics as described in DCS Policy. Training hours are documented in the current child welfare information system.
- b) Each foster parent completes 15 hours of in-service training each year to remain in good standing. Completion of these trainings is documented in the Foster Home Maintenance Database and maintained in the agency foster home file.
- c) The agency provides foster parents with training to meet the needs of each child placed in the home. This includes individual or group training, ongoing in-services, and any required or requested specialized trainings needed to meet the needs of the youth.

4. Individualized Treatment/Service Plan

- a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency along with the Child and Family Team, using a Child and Family Team Meeting approach. This plan supports the permanency goal(s) of the DCS Permanency Plan and provides details specific to the agency's role in supporting the child and family in achieving permanency. The Treatment/Service plan, reviewed quarterly, includes child and family visitation as detailed in the child's Permanency Plan. (See Section One, Core Standards, Chapter III for complete information on Treatment/Service planning requirements.)
- b) Contract agency case managers address needs identified by the CANS in the Treatment/Service planning. Any CANS domain scored a "2 or "3" is considered in the Treatment/Service plan.
- c) The agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan.

5. Service Components and Overview

- a) Agency Responsibilities and Services
 - ◆ When placing a child/youth in a foster home, the agency will share all available pertinent information regarding the child/youth's record with the foster family.
 - ◆ Prepare the child/youth for placement with a specific foster family to help with adjustment.
 - ◆ Provide case management and coordination of services, including support of the DCS Permanency Plan and participation in the Child and Family Team.
 - ◆ Assist in preparing the child/youth for return home or for placement in a stable, nurturing, permanent environment
 - ◆ Assist and support the child in receiving outpatient therapy, if indicated, up to twice

monthly.

- ◆ Assist and support the child in receiving medication management, if indicated. Medication management (psychopharmacological treatment) is accessed at least quarterly or more often as medically necessary.
- ◆ Coordinate health services, including arranging and accessing community based medically necessary health services through TennCare and private insurance.
- ◆ Provide educational liaison to interact with the child/youth's educational needs and individualized educational plan. The educational liaison may be the foster parent. Contact with the youth's school will occur as needed and be documented in the youth's record.
- ◆ Provide recreational activities, daily living skills and interdependent living skills. These activities are appropriate to, and adapted to, the needs, interests and ages of the service recipients and are community based (e.g. community center, clubs, churches, sports). More information about independent living may be found in the IL Core Services portion of this manual.
- ◆ Provide information to DCS about family activities and progress toward the goal of permanency.
- ◆ Provide services to help the child's permanency family maintain and enhance parental functioning, parental care, and parental ties unless the child/youth's safety would be compromised.
- ◆ Providers meet with the child/youth's parent(s) without the child/youth at least one time per month. Goals for these meetings include:
 - Evaluate safety, well-being, and permanency
 - Monitor service delivery
 - Assess and support the achievement of permanency and other treatment plan goals.
- ◆ Assess and support the achievement of permanency and other treatment plan goals
- ◆ DCS and active Contract Providers may agree to share foster homes for DCS youth. Specific agreements must be documented in writing and signed by the DCS and the Contract Provider. For specific details, please refer to **DCS Policy [16.11 Shared Foster Homes](#)**
- ◆ Provide board rates that meet or exceed the basic board rates outlined in **Policy [16.29, Foster Home Board Rates](#)** and **Policy [16.8, Responsibilities of Approved Foster Homes](#), Attachment 1, Guidelines in Supplemental Respite Care**
- ◆ Providers adhere to **DCS Policy [16.43 Supervised and Unsupervised Visitation between Child/Youth, Family and Siblings](#)**.
- ◆ Providers adhere to **DCS Policy [16.38 Face-to-face Visitation with Dependent and Neglected and Unruly Children in DCS Custody](#)**
- ◆ Providers adhere to **DCS Policy [16.4, Foster Home Selection and Approval](#)**

2 – FOSTER CARE

- ◆ Providers adhere to Section G of **Policy 16.46: Child/Youth Referral and Placement** when determining how many youth to place in a foster home.
- b) Foster Family responsibilities and services
 - ◆ Foster parents adhere to **DCS Policy 16.8, Responsibilities of Approved Foster Homes,**
 - ◆ Assume an integral role in providing care and services for children placed in their homes.
 - ◆ Provide safe, stable care in a nurturing environment to facilitate permanency as well as to promote development and growth.
 - ◆ Provide guidance, structure, protection, and offer participation/inclusion in as many positive experiences as possible.
 - ◆ Work constructively within the policy framework in developing plans and meeting the needs of the child and his/her family.
 - ◆ Provide information to the agency regarding the needs of a child in care.
 - ◆ Accept and use professional consultation including mental health and educational assistance.
 - ◆ Participate fully in therapeutic and medical services provided for the child/youth.
 - ◆ Participate fully in social and educational services (e.g., PTA meetings, parent-teacher conferences, etc.).
 - ◆ Provide opportunities for the child to participate in appropriate extra-curricular activities (sports, dance, band, Scouts, etc.) in order to enhance his/her strengths and address needs.
 - ◆ Provide developmentally appropriate activities and support designed to prepare the child/youth to lead self-sufficient adult lives, in accordance with their service plan.
 - ◆ Encourage maintenance of contact with the child/youth's family or "circle of support" and provide support in making such arrangements, unless specifically contraindicated because of the child's safety;
 - ◆ Assist in maintaining the relationship with siblings through visits (no less than monthly), and shared activities unless contraindicated because of the child's safety or contradictory to treatment plan or court order, if they are not placed in the same foster home (includes Juvenile Justice Youth in YDCs).
 - ◆ Provide routine transportation for the child/youth placed in their home (150 miles or less round-trip).
 - ◆ Maintain confidentiality regarding the child/youth and his or her birth parents;
 - ◆ Work in partnership with the agency and the Department of Children's Services to make key decisions related to the placement of children and termination of parental rights.
 - ◆ Assist in preparing the child/youth for return home or for placement in a stable, nurturing, permanent environment.

2 – FOSTER CARE

- ◆ Foster parents will be home at all times if a private duty nurse is serving the youth. The use of a TennCare nurse does not replace the need for a foster parent or other adult caregiver to be present in the home with the child. The Bureau of TennCare rules state “To the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during provision of the private duty nursing services in order to assure the child’s non-health care needs are addressed. General childcare services and other non-hands-on assistance such as cleaning and meal preparation will not be provided by a private duty nurse.” (Paragraph 80-Private Duty Nursing Services of rule 1200-13-13-.01 of TennCare rules)

6. Education of the Child/Youth

- a) Children/youth in standard foster care with emotional/behavioral health care needs typically attend public school.
- b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

7. Records Management

- a) The agency foster home file will indicate the functional capacity of the home, which can be described as the maximum number of children the foster home is approved for within the home study and agreed upon by the foster parents and home study writer. Functional capacity is the actual number of children that the foster parent(s) can serve and is not necessarily the maximum number of children allowed in the home per DCS Policy [16.46. Child Youth Referral and Placement](#). Please note that the functional capacity cannot exceed the maximum number allowed.
- b) Case records contain information regarding the agency’s efforts to promote Permanency/Treatment Plan goals. Documentation will record, in detail, the agency’s attempts to assist the family in:
 - ◆ Making a permanency plan for their child;
 - ◆ Visiting and maintaining contact with their child;
 - ◆ Overcoming barriers to their involvement in the child’s care, contact or visitation; and
 - ◆ Utilizing the resources the agency offers to prepare the family for reunification.
- c) Document meeting with the child/youth’s parent(s) at least one time per month. Goals for these meetings include:
 - ◆ Evaluate safety and well-being, and permanency;
 - ◆ Monitor and document service delivery; and
 - ◆ Assess and support the achievement of permanency and other treatment plan goals.

- d) Contract providers ensure timely documentation of Parent/Child Visits in TFACTS within 30 days of visits occurring. The provider ensures that the entry includes all required non-narrative information including each participant listed at the visit. When visits cannot occur, are canceled, or caregivers do not show, those types of visits are also documented.

A narrative summary of all visits are included in the monthly summary.

- e) Providers are also required to enter other types of contact into TFACTS on a monthly basis. Those types of face-to-face contacts required to be entered include:

- ◆ **Face-to-Face Contact with Child or Youth** - This is used when a contract provider case manager makes actual, physical face-to-face contact with the child or youth.
- ◆ **Family/Sibling Visitation Face-to-Face Contact** - This is used when the child or youth visits with a sibling or other family member (such as a parent or other relative) and a contract provider case manager or other case management staff who meet the requirements for face-to-face are also present for the visit.
- ◆ **Family/Sibling Visitation NOT Face-to-Face Contact** - This is used when a child or youth visits with a sibling or other family member (such as a parent or other relative) and a contract provider case manager or other case management staff are NOT present for the visit. This may be used when DCS support staff or contract provider staff provides supervision.

Note (1): Each family/sibling visitation that occurs must be entered separately. For example, if a child has four (4) separate visits with a parent, there should be four (4) separate entries. This allows the provider to receive full credit for all of the parent/sibling visits. However, if a parent/child visit occurs and consists of multiple days in duration (such as over a weekend or collective days for a holiday); it only should be entered one (1) time and would only be considered one (1) visitation.

Note (2): Providers are not required to include a narrative along with the entry of face-to-face contacts. A narrative summary of all visits must be included in the Monthly Summary.

8. Discharge Criteria

- a) The Child and Family Team reviews the permanency plan at scheduled intervals or when needed. The CFT determines when goals for permanency have been met and recommends discharge with input from all members of the child/youth's team.

b) Discharge includes planning for the child's:

- ◆ Educational needs;
- ◆ Additional support for stability for the child and family;
- ◆ A plan for accessing community support;
- ◆ An inventory of the child's personal items to ensure availability at time of discharge;
- ◆ Emotional and behavioral needs (continuation or referral for services);
- ◆ Accessing health insurance; and
- ◆ Needs identified by CANS that still need to be addressed on trial home placement or exit from care.

THERAPEUTIC FOSTER CARE SERVICES

1. General Characteristics

Therapeutic Foster Care Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate.

The child/youth requires a higher level of clinical support, intervention and case coordination than those eligible for standard foster care. Their emotional/behavioral needs within the family are met through care by parents who have received standard foster parent training as well as specialized training to meet the higher therapeutic needs of the children/youth they serve. Moreover, the child/youth's emotional/behavioral clinical needs are moderate and can be met through community and/or outpatient services.

2. Admission/Clinical

Children/youth appropriate for Therapeutic Foster Care:

- a) Are unable to receive the parental care they need in their own home.
- b) Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others.
- c) May be of any adjudication type and are not excluded from admission when their risk is low or they have successfully completed a treatment program. For information about

youth adjudicated delinquent in foster care, refer to DCS Policy [16.46 Child/Youth Referral and Placement.](#)

- d) May have a history of moderate mental health, and behavioral concerns that require monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms which are moderate or transiently severe in nature. These may manifest themselves in difficulty coping socially, occupationally, or in school functioning.
- e) Have a Child and Adolescent Needs and Strengths (CANS) recommending Level 2 or Level 3 services. The child or youth scores a 2 or 3 within the domain of child behavioral or emotional needs, such as psychosis, anxiety, adjustment to trauma and an elevated rating on either life domain functioning or child risk behaviors.

3. Personnel and Foster Parents

a) Foster Parent training

In addition to the Standard Foster Care pre-service training, all newly approved therapeutic foster parents are required to complete additional hours of specialized training targeted toward the population to be served (i.e. mental health, juvenile justice) prior to caring for the children/youth.

- ◆ **Juvenile Justice**

- 9 hours of Juvenile Justice Training – Parenting the Youthful Offender Curriculum

- ◆ **Mental Health**

- Fifteen (15) hours of behavioral/mental health oriented training which addresses at a minimum the following topics:

- Policy and Procedures
 - Protocol / Professional Expectations for Foster Parent
 - What is behavioral/mental health foster parent care?
 - YOUR RIGHTS as a Foster parent
 - Confidentiality
 - Emergencies
 - Additional Services and assistance in home care
 - Education services for child that is behavioral/mental health
 - Engaging families and birth parents
 - Common Conditions of Children
 - Understanding Growth and Development
 - Trauma and its effects on the child/youth
 - Mental Health Support
 - Preparing for the child/youth to leave home

- Self-Care for Caregivers
- ◆ Additionally, therapeutic foster parents will receive specialized training on the specific mental health or behavioral needs of each child/youth to be placed in their home
- b) Agency staff training
Contract provider case managers will complete specialized pre-service training targeted toward the population they will serve.
- c) Foster parents providing continuum foster care services have the maturity to be able to care for children/youth needing this higher level of service. It is recommended that these foster parents be at least twenty-five (25) years of age. If the foster parent is not at least twenty-five (25) years of age, the agency can still approve the parent by documenting that the parent has shown the maturity to be able to perform these services. Documentation can take the form of letters of reference and interviews discussing this issue specifically. Currently approved parents not meeting this age limit will remain approved (grandfathered in).

4. Individualized Treatment/Service Plan

- a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency along with the Child and Family Team, using a Child and Family Team Meeting approach. This plan supports the permanency goal(s) of the DCS Permanency Plan and provides details specific to the agency's role in supporting the child and family in achieving permanency. The Treatment/Service plan, reviewed quarterly, includes child and family visitation as detailed in the child's Permanency Plan. (See Section One, Core Standards, Chapter III for complete information on Treatment/Service planning requirements.)
- b) Contract agency case managers address needs identified by the CANS in the Treatment/Service planning. Any CANS domain scored a "2 or "3" is considered in the Treatment/Service plan.
- c) The agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan.

5. Service Components and Overview

- a) Providers adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.
- b) Foster parents adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.

6. Education of the Child/Youth

- a) Children/youth in therapeutic foster care with emotional/behavioral health care needs typically attend public school.
- b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

7. Records Management

- a) The agency foster home file will indicate the functional capacity of the home, which can be described as the maximum number of children the foster home is approved for within the home study and agreed upon by the foster parents and home study writer. Functional capacity is the actual number of children that the foster parent(s) can serve and is not necessarily the maximum number of children allowed in the home per DCS Policy [16.46, Child Youth Referral and Placement](#). Please note that the functional capacity cannot exceed the maximum number allowed
- b) Case records contain information regarding the agency's efforts to promote Permanency/Treatment Plan goals. Documentation will record, in detail, the agency's attempts to assist the family in:
 - ◆ Making a permanency plan for their child;
 - ◆ Visiting and maintaining contact with their child;
 - ◆ Overcoming barriers to their involvement in the child's care, contact or visitation; and
 - ◆ Utilizing the resources the agency offers to prepare the family for reunification.
- c) Document meeting with the child/youth's parent(s) at least one time per month. Goals for these meetings include:
 - ◆ Evaluate safety and well-being, and permanency;
 - ◆ Monitor and document service delivery; and
 - ◆ Assess and support the achievement of permanency and other treatment plan goals.

8. Discharge Criteria

Please refer to the Standard Foster Care portion of this chapter.